Gastrointestinal and Liver Specialists of Tidewater, PLLC
Pre-procedure Questionnaire

Patient Name:________________________________ Date of Birth:______________

Procedure Date:__________________

Who will drive you home after your procedure?____________________________

Is your ride waiting here (circle)? Yes No Phone # if not here: ____________________

DO YOU CONSENT FOR YOUR DRIVER TO BE GIVEN INFORMATION ABOUT YOUR PROCEDURE?

Yes☐ No☐ Initial: ____________________

Do you have any of the following?

Pacemaker or defibrillator	Yes☐	No☐
High Blood Pressure	Yes☐	No☐
Cardiac Problems	Yes☐	No☐
Stroke, TIA or clotting problems	Yes☐	No☐
Do you take blood thinners?	Yes☐	No☐
**(Coumadin, Heparin, Plavix, Aspirin, Ticlid, Persantine) Date Stopped:__________		
Liver disease/hepatitis	Yes☐	No☐
Respiratory/Lung problems	Yes☐	No☐
Sleep Apnea	Yes☐	No☐
Artificial heart valve or joint replacement	Yes☐	No☐
Approximate date of that surgery:__________________		
Physical limitations	Yes☐	No☐
**If yes, please list:__________________		
Glaucoma	Yes☐	No☐
Diabetes (Circle: Pills or Insulin)	Yes☐	No☐
Difficulty with anesthesia or sedation	Yes☐	No☐
History of seizures	Yes☐	No☐
Kidney problems	Yes☐	No☐
Do you have any loose, chipped, or cracked teeth?	Yes☐	No☐
Cancer (Type:)	Yes☐	No☐
Allergy or sensitivity to latex	Yes☐	No☐
Allergies to medications	Yes☐	No☐
**If yes, please list:__________________		
ALL WOMEN: Is there any possibility that you are pregnant?	Yes☐	No☐
Date of last menstrual period:__________________Signature:__________________		
Have you had a mastectomy or lumpectomy?	Yes☐	No☐

Please list any medications you have taken in the last 24 hours

____

Notes: ____

Reviewed By (including current Medications): ________________________(Nurse Signature)

Gastrointestinal and Liver Specialists of Tidewater, PLLC
Consent for Colonoscopy

Patient Name: ________________________________

Procedure Date: __________________ Acct#: __________

D.O.B: _____________ Performing Dr: _________________

Authorization and Nature of this Procedure: I hereby request and authorize Dr. ____________________ and his/her designated associates/assistants to perform a **colonoscopy and possible polypectomy or biopsy**. It has been explained to me that this procedure is an examination of the lining of the large intestine (colon) by use of a flexible scope, which is passed through the rectum into the colon. During this procedure biopsies (tissue samples) may be removed. If a polyp is detected which is removable, it will be removed with or without the use of electrocautery. I understand that there are several techniques to remove polyps/lesions and I authorize my physician to utilize whichever method he feels is best suited during this procedure. Small polyps are sometimes cauterized without tissue removal. Occasionally when bleeding occurs, cautery or the injection of medication may be necessary to stop the bleeding. I am also aware that sometimes the physician will mark the area of the colon that was treated, so that this area can be more easily re-evaluated in the future.

Risks and Complications: Every medical procedure has some degree of risk and the possibility of complications. My physician has explained to me and I understand that complications from this procedure include but are not limited to: a perforation or hole in the colon, bleeding, infection, rarely rupture of the spleen or irregular heart beat. Very rarely, death has been reported with this procedure. I understand that unusual complications, so rare that they are not routinely discussed before this test occasionally do occur. I do not wish to have any further explanation given to me, although I have been advised that I am entitled to do so if I desire. I understand that I may be transferred to another facility in the event that a complication occurs. This decision will be made by my physician or designated health care provider.

Alternative Procedures or Treatment: My doctor has explained to me that alternative procedures are available which also include risks and complications. I am satisfied with my physician's explanation of these options and wish to proceed with a colonoscopy. Such options may include x-rays, barium enema, CAT scan, or no treatment.

Attendance of other Health Care Providers: I understand that physicians, nurses and assistants may be present to perform and assist with my colonoscopy. I consent to the presence of these health care professionals and **I do_____/I do not_____** consent to *students/residents/personnel in training* to be present during my procedure.

Photographs: I understand that photographs and/or videotaping may be taken during my procedure for documentation of findings. **I do_____/I do not_____** consent to the use of these photographs to be used for teaching purposes. This may include the reproduction of the photographs for publication or to be used in part of a medical education program.

Anesthesia/Sedation: I consent to the administration of intravenous (IV) medications that will have a sedative effect on me. Possible complications from this may include but are not limited to pain during the administration of medications, soreness/swelling in the arm, cardiac or respiratory arrest, rarely an allergic reaction, which could cause death. I understand that I cannot drive after the procedure until the following morning; I should not sign any legal or important papers or perform tasks that require coordination. I should have a responsible adult with me for the remainder of the procedure day.

Tissue Disposal: I consent to the appropriate disposal of any body tissues removed during this procedure after the same tissue has been examined by a pathologist.

No Guarantee or Assurance: I acknowledge that no guarantee or assurance to the outcome of this procedure has been given to me. I do recognize that this is the best test for finding lesions in the colon; however, I understand that there are a low percentage of missed lesions, not limited to polyps or colon cancer (about 2-5%) associated with this procedure.

No ADVANCE DIRECTIVES: I acknowledge that this facility does NOT recognize advance directives. During my care at this facility, all practical measures will be utilized to prevent loss of life. ______________________________ (patient initial or signature)

Opportunity for Further Information: I understand that I am free to seek advice from other physicians if I choose. I know that I am also encouraged to ask questions regarding any aspect of this procedure, which I am unclear or unsure of.

Opportunity to Read this Document: I acknowledge by signing this consent that I have read this form in its entirety and fully understand it. I have had my questions answered to my satisfaction and agree and consent to this treatment.

DO NOT SIGN IF YOU HAVE FURTHER QUESTIONS

____ ____________________

Signature of Patient or Authorized Person Date

Authorized person's relationship to the patient: ___________________________________

____ ____________________

Signature of Witness Date

The above procedure(s) have been explained to the patient or authorized person to give consent for the patient.

________________________________, M.D.

Verifying Insurance Benefits for cases with/without MAC (Monitored Anesthesia Care)

Benefit coverage varies widely from not just insurance company to insurance company but from plan to plan at each insurance company. This makes it impossible for us to know exactly what your specific insurance plan will cover for you.

Verifying your insurance benefits before undergoing a procedure helps you understand ahead of time what your specific insurance covers. We are providing this information sheet to help you with this process. You will need to call the phone number on the back of your insurance card to verify exactly what your insurance will cover.

You will need to know a couple of key pieces of information in order to verify your benefits:

Procedure codes:
The basic upper endoscopy (EGD) or lower endoscopy (colonoscopy) are considered "diagnostic". These are exams that just examine either the upper or lower GI tract. Once something is seen that should be biopsied, removed or treated, the procedures then become a "therapeutic" procedure. In verifying your coverage you should check benefits for both a diagnostic and a therapeutic procedure as your coverage MIGHT be different for each type. At this time also verify your coverage for Anesthesia during your procedure. For most insurances, what the anesthesiologist provides is called "General" but Optima calls it "MAC" anesthesia.

The codes that most likely will be used to identify your endoscopic procedure(s) is/are as follows.

Upper Endoscopy (EGD):
43235 (diagnostic)
43239 (therapeutic)
43248 (therapeutic)
43249 (therapeutic)

Colonoscopy
45378 (diagnostic)
45380 (therapeutic)
45381 (therapeutic)
45385 (therapeutic)

The place of service is also identified with codes:
Outpatient hospital: 22
Office: 11
Surgical facility: 24

If you are having your procedure at the hospital as an outpatient, you will use code 22. If you are having your procedure in one of our office endoscopy units, you will use code 11 EXCEPT for the following insurance companies:

United Healthcare**
Coventry/Southern Health//First Health**

**We have been mandated by contract with these companies to bill using place of service code 24.

If you find that you need assistance with this process or you are given any specific information that will assist us in filing your claims, please contact our billing department at 627-9986.

I acknowledge receipt of this form:
Signature:______________________________ Date:______________

Procedure Date____________ Time______

POST-PROCEDURE RIDE POLICY

I understand that I am responsible for bringing a driver to drive me home after my procedure on ____________________. If I arrive in the office without a driver, I will have to sign a notice that I will be billed $50.00 for every 15-minute interval past my approved discharge time until my driver arrives. I acknowledge that this charge is not billable to my insurance and that I will personally be responsible for its payment in full at the time of the occurrence by means of cash or credit card.

Patient Signature: ______________________________ **Date:**________________

Printed Patient Name: ___________________________

Witness Signature:______________________________

THIS POLICY IS FOR YOUR PROTECTION! WE CANNOT RELEASE A PATIENT WITHOUT A CONFIRMED RIDE!

PROCEDURE "NO SHOW" POLICY

Failure to keep scheduled procedure appointments will result in a financial penalty. For procedure appointments that are not kept or not cancelled with at least 48 hours notice, you will be charged $50.

For EUS (endoscopic ultrasound) procedures, 72 hours notice is required or you will be charged $500. Endoscopic Ultrasound is a very specialized procedure that utilizes a lot of hospital resources as well as takes a large block of the physician's time to complete. The number of appointment slots for this procedure are very limited, therefore the time allocated to endoscopic ultrasound is very important. Failing to keep a scheduled endoscopic ultrasound appointment prevents another patient from being able to utilize that time slot and those resources.

"No Show" fees must be paid prior to rescheduling and failure to pay the fee may result in dismissal from the practice.

I have read and understand the above "No Show Policy"

Patient Signature:________________________________**Date:**________________

GLST AUTHORIZATION FOR ANESTHESIA SERVICES

Facility: ___________________________
Patient Name: ____ Medical Record #: ____________________
Date of Service: ________________________ Account #: ________________
IMPORTANT INFORMATION
PLEASE READ CAREFULLY

1. **Anesthesiology staff** are independent in the exercise of decisions requiring professional medical judgment, including decisions about my care.

2. **Assignment and Coordination of Insurance Benefits –** I agree to provide information regarding all group hospitalization, health maintenance organization, workers' compensation, automobile, and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefits plan(s) to GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC.

3. **Unauthorized, Non-Covered, or Out of Plan Services** – I understand that if my insurance company or health maintenance organization does not consider this or any service rendered during this procedure a covered service or has not authorized this service, they will not pay for the services, or a particular charge for a service rendered during this outpatient visit. I agree to be fully responsible for payment to GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC for providing services to me/the patient for this procedure or any related service if determined by my insurance company or health maintenance organization to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, deductible, co-insurance of the charge. I also understand that GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC may not participate with all health plans and networks, and may not be in-network physician members of my managed care health plan. In the event that my managed health care plan does not reimburse these services provided to me, I acknowledge that I will be responsible for any balance that it declines to pay for such services.

4. **Authorization to Release Information and Process Claims –** I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this care or any related services to my insurance carrier(s). A photocopy of this authorization may be honored.

5. **Responsibility for Payment –** In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, co-insurance and non-covered services. I request and authorize that payment of authorized Medicare benefits be made on my behalf to GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC for services rendered to me.

In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.
By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions, and have them answered, and accept the above conditions and terms. I further certify that I am the patient listed above or I am the guardian, duly authorized representative, parent or other family member of the patient.

X____
PATIENT (GUARDIAN, ETC.) DATE

____
RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

____
WITNESS DATE

____

Rev. 1.2018

Gastrointestinal & Liver Specialists of Tidewater, PLLC

INFORMED CONSENT FOR ENDOSCOPY ANESTHESIA

PLAN FOR ANESTHESIA

☐

PREANESTHESIA EVALUATION

☐ Pre-Procedure Assessment complete
☐ Chart reviewed & Patient/Guardian Interviewed
☐ Patient's medical history, medications, and pre-op data were reviewed

☒ **MAC / IV Sedation**	Expected result	Reduced anxiety and pain, decreased awareness, possibly not remembering events during the procedure
	Risks (not limited to)	Decreased breathing with need for assistance
General Anesthesia	Expected result	Reduced anxiety and pain, decreased awareness to no awareness of events during the procedure
	Risks (not limited to)	Nausea/vomiting, decreased breathing with need for assistance, possible placement of a tube into the windpipe, mouth or throat pain, hoarse voice, injury to mouth or teeth, injury to blood vessels, injury to nerves, breathing problems from stomach contents entering the lungs, pneumonia
☐ **No Sedation/ Monitoring Only**	Expected result	Monitoring of vital signs, availability of anesthesia staff for assistance
	Risks (not limited to)	Awareness, anxiety, discomfort

- I understand that the items checked above are a plan and there may be a need to change to a different type of anesthesia. This may include doing general anesthesia with an airway device (if not alreadyplanned).
- I understand that there are risks with all type of anesthesia. Rare events include infection, drug reaction, prolonged or permanent loss of sensation or movement in the arms or legs, loss of vision, brain damage, heart attack or death.
- I consent to the anesthesia service(s) checked above. I understand that the anesthesia will be given by an Anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) who is under the medical direction of a qualified physician. All anesthesia staff have credentials to provide anesthesia services at thisfacility.
- I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

PATIENT/ Designated Decision Maker:________________________________ Date:__________ Time: ________

Witness:____ Date:__________ Time: _________

I have performed the necessary preoperative anesthesia evaluation. I have explained the anesthesia plan and its common risks, alternatives and expected results. I have answered the patient's/designated decision maker's questions with regards to anesthesia care to his/her satisfaction.

Comments____

ANESTHESIA PROVIDER:__________________________ MD/DO/CRNA Date:__________ Time: __________

Patient Name/ DOB ______________________________

Patient Identification

Rev. 1.2018